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No. 04-1506

In The

Supreme Court of the United States

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Petitioners,

v.

HEIDI AHLBORN,

Respondent.

On Writ Of Certiorari to the United States Court of Appeals for the Eighth Circuit

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BRIEF OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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BRIEF OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Association of Trial Lawyers of America ("ATLA") respectfully submits this brief as *amicus curiae.*[1] The parties have filed letters of consent to the filing of this brief with the Clerk of the Court.

[1] Pursuant to Rule 37.6, Amicus discloses that no counsel for a party authored any part of this brief, nor did

ATLA is a voluntary national bar association whose approximately 50,000 members primarily represent individual plaintiffs in civil actions brought under state tort law. Many of the injured plaintiffs represented by ATLA members have received or will receive medical treatment for their injuries paid for by Medicaid.[2] As a result, ATLA members and their clients are directly affected by the construction of statutory provisions in the federal Medicaid Act concerning repayment of medical expenses to state Medicaid agencies out of proceeds obtained from liable third parties through litigation.

ATLA is concerned that the position advocated by petitioner and the United States in this matter would have seriously adverse consequences for persons injured by tortious misconduct. If, as petitioner asserts, state Medicaid agencies are entitled to full repayment of medical expenses out of all litigation proceeds—before any funds go to the injured plaintiffs, and even when a claim is compromised and settled—many plaintiffs will have no incentive to pursue valid claims, thereby allowing

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any person or entity other than Amicus Curiae, its members, or its counsel make a monetary contribution to the preparation or submission of this brief.

[2] Many others have received or will receive medical treatment paid for by some other federal health care program. Although the present case concerns only Medicaid, very similar issues of third party liability and repayment arise under other federal health care programs, including Medicare and health care programs for servicemen and veterans. *See* Medicare Secondary Payer Act, 42 U.S.C. § 1395y; Medical Care Recovery Act, 42 U.S.C. §§ 2651-53.

their tortfeasors to escape responsibility, while many other plaintiffs will have little financial incentive to accept otherwise reasonable settlement offers and thus will be compelled to press their claims to trial, thereby burdening our courts. By contrast, the rule adopted by the Court of Appeals below, which allows for the equitable allocation of limited settlement recoveries between damages for medical expenses—which may be paid by and, to that extent, reimbursable to state Medicaid agencies—and other damages unrelated to medical treatment, is not only fair both to injured plaintiffs and to Medicaid; this rule also will serve the interests of justice, promote the efficient resolution of legal disputes and, in all likelihood, increase the amount of third party liability payments recouped by Medicaid.

SUMMARY OF ARGUMENT

Each year, hundreds of thousands of lawsuits are initiated across the country seeking compensation for injuries caused by tortious conduct. The vast majority of these lawsuits are eventually resolved by settlement, often for less than the full value of the damages suffered by the plaintiffs. *See* Mark Galanter, *The Hundred-Year Decline of Trials and the Thirty Years War*, 57 Stan. L. Rev. 1255, 1272-74 (2005). There are many reasons why a tort plaintiff may decide to settle a case for less than full value: *e.g.*, the inherent risk of litigation, the increased cost of taking a case to trial, problems of proof, a potential finding of contributory or comparative negligence, and limitations on the defendant's ability to pay full compensation. Most plaintiffs and their counsel recognize and accept these inherent limitations on their ability to obtain a complete recovery.

Petitioner, the Arkansas Department of Health and Human Services ("DHHS"), contends that it should be immune from these litigation uncertainties whenever it seeks to obtain reimbursement for medical expenses paid by Medicaid from a potentially liable third-party tortfeasor. In petitioner's view, its claim for reimbursement should take priority over an injured plaintiff's claim against the same tortfeasor for any other category of damages, including loss of past wages and of future earning capacity, permanent disability, pain and suffering, and past and future medical expenses not covered by Medicaid. Accordingly, petitioner insists that, when a tort claim is settled for less than full value, the state Medicaid agency must be reimbursed in full before any recovery can go to the injured plaintiff.

Amicus respectfully submits that this Court should reject petitioner's demands. There are three reasons why. First, DHHS's argument is not supported by the language of the Medicaid Act. Second, its position would significantly impede the efficient resolution of judicial proceedings. Finally, petitioner's proposed scheme would likely diminish Medicaid's overall third-party liability recoveries, and thus is inconsistent with Congress' goal of reducing Medicaid's net costs. By contrast, a rule of equitable apportionment of settlement proceeds among all claimants, including the state Medicaid agency, would be consistent with the statutory scheme, would promote judicial economy, and would likely increase Medicaid's third-party liability reimbursements.

ARGUMENT

I. Petitioner's Claim of Priority in Reimbursement Is Not Supported by the Statutory Language of the Medicaid Act.

The statutory language of the Medicaid Act does not support DHHS's contention that a state Medicaid agency's claim for reimbursement must take priority over an injured plaintiff's claims for compensation for her injuries. To be sure, as petitioner maintains, the third-party liability provisions of the Act clearly make Medicaid's responsibility to pay for a plaintiff's medical treatment secondary to that of the defendant tortfeasor. Significantly, however, the Act says nothing about the relative priority of the state Medicaid agency's claim for reimbursement of medical expenses and the injured plaintiff's claims for other types of damages.

The Act requires the state Medicaid agency, in cases where a third party is liable for the cost of medical assistance paid by Medicaid, "to *seek* reimbursement for such assistance to the extent of such legal liability." 42 U.S.C. § 1396a(a)(25)(B) (emphasis added). To facilitate that effort, the Act declares that the state Medicaid agency "is considered to have acquired the rights of [the Medicaid recipient] to payment by any other party *for such health care items or services,*" 42 U.S.C. § 1396a(a)(25)(H), and further requires the recipient to assign to the state agency his or her "right to payment *for medical care* from any third party," 42 U.S.C. § 1396k(a)(1)(A), and "to cooperate . . . in *pursuing*[] any third party who may be liable to pay

for care and services available under the plan." 42 U.S.C. § 1396k(a)(1)(C) (emphases added).

The Medicaid Act does not require that the state Medicaid agency obtain full reimbursement of its medical expenses from the third party—which in many cases might prove to be difficult or impossible—but merely that the agency "pursue" the potentially liable third party and "seek" reimbursement.[3] Moreover, the state agency does not acquire any rights to any portion of the injured plaintiff's tort claims other than the claim for reimbursement of medical expenses paid by Medicaid. *See Wilson v. State*, 10 P.3d 1061, 1069 (Wash. 2000), *cert. denied*, 532 U.S. 1020 (2001) (Alexander, J., joined by Johnson, Sanders, and Ireland, JJ., dissenting) ("plain language in 42 U.S.C. § 1396a(a)(25)(H) . . . limits a state from acquiring any part of the recipient's recovery from a third party beyond the payment 'for such health care and services'"). The claims for damages unrelated to medical treatment remain the property of the injured plaintiff, who may seek her own recovery from the tortfeasor. Indeed, the Medicaid Act itself shields any recovery for other items of damage from the state Medicaid agency—at least during the life of the Medicaid recipient—by prohibiting the state agency from placing a lien on those proceeds. 42 U.S.C. § 1396p(a)(1).

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[3] The United States, as *amicus curiae*, confirms this, explaining that "[w]here the State is notified and given an opportunity to participate in settlement negotiations, it may compromise its claim in appropriate circumstances . . . ." Brief for the United States at 13.

Most importantly, nothing in the text of the Act grants the state Medicaid agency's right to repayment from the third-party tortfeasor any priority over the injured plaintiff's right to recover for other types of damage.[4] Such legislative silence speaks volumes about the injured plaintiff's right to retain an equitable portion of any recovery.[5]

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[4] Petitioner and its *amici* attempt to wring some textual support for their position out of a statutory provision that is wholly inapplicable to the situation before the Court, 42 U.S.C. § 1396k(b). *See* Petitioner's Brief at 13; Brief for the United States at 12-13. That provision relates to amounts collected by the state Medicaid agency through litigation it initiates pursuant to the Medicaid recipient's assignment of rights to third-party payments under 42 U.S.C. § 1396k(a)(1)(A). Because such an assignment is limited to "payment for medical care from any third party," *id.*, it is not surprising that the Act permits the state agency to retain amounts collected pursuant to the assignment up to the level required for full reimbursement of medical assistance payments. 42 U.S.C. § 1396k(b). But that section says nothing about the state agency's right to lay claim to amounts recovered for types of damages other than medical expenses, especially through cases brought by the injured plaintiff herself.

[5] Indeed, in most states, it is the claims of an injured plaintiff that take priority over the subrogated claims of an entity that paid for the plaintiff's medical care. Under the "made whole" doctrine, a health insurer may not obtain reimbursement for medical payments from a third-party tortfeasor until the injured plaintiff has been fully compensated for his damages. *See* Johnny C. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation*, 70 Mo. L. Rev. 723, 738-73 (2005)(34 states have adopted the made whole doctrine by statute or court decision).

Reading the third-party liability provisions of the Act in conjunction, and in harmony, with its anti-lien provision leads inexorably to the conclusion reached by the court below.

Unable to find any support in the text of the Act, DHHS and its *amici* attempt to make much of the statement found in a 1985 Senate Report to legislation modifying Medicaid's third-party liability provisions that Medicaid "is intended to be the payer of last resort." S. Rep. No. 99-146 at 279 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312. But this brief expression of legislative intent says nothing more than the statute itself: Medicaid shall not be obliged to pay for medical expenses for which payment can be obtained from a liable third party. The Senate Report does not say that the injured Medicaid recipient must repay the state Medicaid agency its medical expenses out of settlement funds received in compensation for other items of damages, nor does the report suggest that a potentially liable third party must satisfy the state Medicaid agency in full prior to offering any compensation to the injured plaintiff.[6]

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[6] DHHS and its *amici* also rely heavily on both formal and informal interpretations of the third party liability provisions of the Medicaid Act by the U.S. Department of Health and Human Services. These agency rulings should be entitled to no deference by this Court, for several reasons. First, as the court below concluded, these administrative rulings are flatly inconsistent with the text of the act, which nowhere grants priority to a state Medicaid agency's claim for reimbursement. *Ahlborn v. Arkansas Dept. of Human Services*, 397 F.3d 620, 626 (8th Cir. 2005), Pet. App. 1, 11. Second, because these agency interpretations involve only

II. Petitioner's Claim of Priority in Reimbursement Is Inconsistent With the Public Interest in Efficient Resolution of Legal Disputes.

Petitioner's claim of priority in reimbursement is not just inconsistent with the statutory language and legislative history of the Medicaid Act; it also poses serious problems for the administration of justice. Most significantly, it would discourage settlements and impede the efficient resolution of legal disputes.

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a straightforward issue of statutory construction and do not involve any particular area of agency expertise, courts are fully capable of rendering their own independent interpretations of the act. Indeed, as Chief Justice Marshall noted nearly two centuries ago, "[t]he judicial department of every government is the rightful expositor of its laws." *Bank of Hamilton v. Dudley's Lessee*, 27 U.S. 492, 524 (1829). *See Adams Fruit Co. v. Barrett*, 494 U.S. 638, 649-50 (1990).

Finally, and perhaps most significantly, the HHS interpretations at issue can and should be disregarded as entirely self-serving; they construe the statute so as to award the greater share of any tort settlement to that entity (the state Medicaid agency) that will, in turn, return a significant portion of the settlement back to HHS. *See United States v. Winstar Corp.*, 518 U.S. 839, 898 (1996)("The greater the Government's self-interest, however, the more suspect becomes" its arguments). *See Amadeo v. Zant*, 486 U.S. 214, 227 (1988); *Loper v. Beto*, 405 U.S. 473, 502 (1972)(Rehnquist, J., joined by Burger, C.J., Blackmun, & Powell, JJ., dissenting); *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 647 (1952)(Jackson, J., concurring).

This Court has long recognized a strong public interest in the expeditious resolution of lawsuits through settlement. *See, e.g., Hines v. Anchor Motor Freight, Inc.*, 424 U.S. 554, 574 (1976)(recognizing "the consistent policy of this Court [to] encourag[e] the parties to settle their differences"); *McDermott, Inc. v. AmClyde*, 511 U.S. 202, 215 (1994)("public policy wisely encourages settlements"). Our state and federal judicial systems would cease to function if all, or even a substantial portion, of cases were litigated to trial. Thus, judges and litigants, as well as the public at large, have a strong "interest in obtaining the most efficient resolution of controversies." *World-Wide Volkswagen Corp. v. Woodson*, 444 U.S. 286, 292 (1980). *See also E.E.O.C. v. Waffle House, Inc.*, 534 U.S. 279, 312 (2002); *Volt Information Sciences, Inc. v. Board of Trustees of Leland Stanford Junior University*, 489 U.S. 468, 478 (1989); *Asahi Metal Industry Co., Ltd. v. Superior Court of California, Solano County*, 480 U.S. 102, 115 (1987).

Petitioner's proposed rule is flatly inconsistent with this public interest. If this Court were to rule for petitioner, an injured plaintiff who had received medical treatment funded by Medicaid would have little incentive to settle her personal injury lawsuit for an amount that fell far short of her total claim for damages, because any settlement award immediately would be reduced by the total amount claimed by the state Medicaid agency for reimbursement of medical expenses paid. In addition, the plaintiff would be obliged to pay her attorneys' fees and costs. Only the remainder would belong to the injured plaintiff. Where the cost of treatment funded by Medicaid was substantial, there would be relatively little, if any, money left to compensate plaintiff for her injuries.

Under this scenario, all of the costs and risks of litigation, and all of the uncertainty about potential recovery, would be borne by the plaintiff. The state Medicaid agency would bear none of this risk, and none of these costs, while obtaining a full recovery.

These settlement problems may be further exacerbated under certain circumstances. If the state Medicaid agency is slow or reluctant to reveal the amount of its reimbursement claim, plaintiff will confront even greater uncertainty about the likely size of her personal recovery.[7] Similarly, if the state Medicaid agency is unwilling to bear its proportionate share of attorneys' fees and litigation costs, the plaintiff's potential recovery from any settlement would shrink substantially.[8]

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[7] Although Ms. Ahlborn does not appear to have experienced any difficulty in this case in obtaining information from DHHS regarding the amount of its claimed lien, such is not always the case. Counsel for *amicus curiae* has received letters from many ATLA members attesting to their frequent difficulty in obtaining lien figures for their clients' claims from federal and state health care agencies. The federal Medicare program and its contractors are notorious for refusing to provide information regarding claimed lien amounts until after a tort claim has been settled. (These letters are on file with counsel and can be made available to the Court upon request.) Under these circumstances, plaintiffs are forced to bear not only the uncertainty of litigation, but also substantial uncertainty about the amount of any recovery that may be claimed by the government for reimbursement of medical costs.

[8] It is unclear to *amicus* whether most state Medicaid agencies are willing to share in plaintiff's costs

For these reasons, plaintiffs with substantial Medicaid reimbursement claims will have strong incentives not to compromise their claims through settlement, but instead to "roll the dice" in hopes of obtaining a sufficient recovery through trial. As a hypothetical, imagine a plaintiff with a tort claim potentially worth $400,000, with one half comprised of medical expenses paid by the state Medicaid agency. The defendant offers a settlement of $200,000. If the plaintiff and the state were to share equitably in such a settlement, the plaintiff would be contemplating a recovery of $100,000 less attorneys' fees, along with repayment to the state agency of half

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of obtaining a recovery through litigation. According to the Brief of the United States, the Secretary of Health and Human Services "allows for deduction of the costs of obtaining the award, including attorneys' fees, before reimbursement of the Medicaid program." Brief of the United States at 3, n.2. But it is unclear whether most states reduce their claim for reimbursement by a proportionate share of the litigation costs or simply allow those costs to be paid first, without any reduction in the Medicaid reimbursement if sufficient funds exist. For example, the relevant Arkansas statute seems to require full repayment of DHHS. *See* Petitioner's Brief at 13, n.7; Ark. Code Ann. § 20-77-302 ("In the event of judgment or award in a suit or claim against a third party, if the action or claim is prosecuted by the recipient alone, the court or agency shall first order paid from any judgment or award the reasonable litigation expenses and attorney's fees. After the payment of these expenses and attorney's fees, the court or agency shall order that the Department of Human Services receive an amount sufficient to reimburse the department *the full amount of benefits paid* on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.") (emphasis added).

its outlay for medical expenses. But if, as DHHS insists, the state agency is entitled to full reimbursement, then the plaintiff would take nothing from the proposed settlement. Plaintiff would have virtually no incentive to agree to the settlement offer.[9] The plaintiff would presumably pursue the lawsuit to trial, at substantially greater expense to both the parties and the judicial system, and at the risk of an adverse verdict that would deprive both plaintiff and the state Medicaid agency of any recovery at all.[10]

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[9] A number of decisions by this and other Courts recognize that litigants evaluate settlement offers on the basis of such economic self-interest. *Compare Evans v. Jeff D.*, 475 U.S. 717, 734, n. 23 (1986) (a party "incentive to settle would be diminished because of the risk that attorney's fees, when added to the original merits offer, will exceed the discounted value of the expected judgment plus litigation costs."); *Independent Federation of Flight Attendants v. Zipes*, 491 U.S. 754, 769 (1989)(Blackmun, J., concurring)(a party "has little incentive to make a similar calculation for elements of the settlement package that burden only third parties."); *Atteberry v. Memorial-Hermann Healthcare Systems ex rel. Atteberry*, 405 F.3d 344, 350 (5th Cir. 2005); *Pinto v. Aberthaw Const. Co.*, 637 N.E.2d 219, 223 (Mass. 1994)(once a party realizes that additional litigation or negotiations will not benefit his own interests but merely that of third-parties, "it may have little or no incentive to continue the litigation to secure a larger settlement or verdict.").

[10] Counsel for *amicus curiae* have on file letters from ATLA members providing anecdotal evidence of cases in which this occurred: a settlement offer equal to or less than the Medicaid lien, a decision to pursue the matter to trial, and a defense verdict resulting in no recovery by either the plaintiff or the state Medicaid agency. Copies

Thus, under the petitioner's proposed rule, many more tort lawsuits will proceed to trial, at substantial cost to the administration of justice. This Court should reject a statutory construction of the Medicaid Act that will so interfere with the expeditious resolution of legal disputes.

III. Petitioner's Claim of Priority in Reimbursement Would Not Further the Legislative Purpose of Reducing Medicaid's Costs.

DHHS's proposed rule is not only incompatible with the public interest in judicial economy, it is also likely to undermine rather than advance the Act's explicit legislative purpose of reducing Medicaid's costs. This perhaps counterintuitive conclusion results from the fact that a rule requiring complete reimbursement of the state Medicaid agency's expenses before any recovery by the injured plaintiff will discourage many plaintiffs from pursuing tort claims for their injuries. And, as the United States acknowledges in its brief, private litigation by an injured plaintiff has distinct advantages over independent litigation by the state Medicaid agency as a means for maximizing the total funds recovered. Brief for the United States at 16-17.

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of these letters can be made available to the Court upon request.

It is also possible that, if the case goes to trial, the court may award the state Medicaid agency less than the full medical expenses incurred by Medicaid. Under these circumstances, the Secretary of HHS ordinarily accepts this determination as controlling. *See* Brief for the United States at 22, n.14.

Under petitioner's proposed rule, a seriously injured tort victim with significant medical expenses paid by Medicaid would have to think twice before proceeding with litigation. Prospective counsel would feel obliged to advise her that any recovery she obtained would be reduced by full reimbursement to the state agency, as well as by the payment of attorneys' fees and costs. If there are substantial doubts about the likelihood of success in the litigation—either because of the risk of an adverse verdict or due to concerns about the defendant's ability to pay damages—the tort victim and her counsel might well conclude that the potential reward is not worth the time, effort, and expense of pursuing litigation.

Even if the injured tort victim is willing to proceed with a suit for damages, she may experience difficulties in obtaining competent counsel on a contingency fee basis. Counsel may well be unwilling to represent a client if that client is unlikely to realize any recovery after repayment of a Medicaid lien, regardless of the merits of the litigation. This will be especially true in circumstances where counsel's fee is likely to be based solely on the recovery actually obtained by the plaintiff, not the total damages paid by the defendant(s). For example, Arkansas law provides that, where an injured plaintiff and the state Medicaid agency jointly litigate a third-party liability claim, plaintiff's counsel shall only be entitled to "reasonable attorney's fees based solely on the services rendered for the benefit of the recipient." Ark. Code Ann. § 20-77-303. That is to say, under such circumstances, a plaintiff's counsel is not entitled to any compensation based on the state Medicaid agency's recovery, even though that

recovery could significantly limit the funds available to compensate the plaintiff for her non-medical injuries.[11]

Counsel for *amicus* has received letters from ATLA members attesting to both of these situations. A number of these letters describe prospective clients who decided not to pursue meritorious tort claims after counsel explained the potential effect of a Medicaid lien on their possible recovery. Many more letters describe counsels' own reluctance or refusal to represent plaintiffs in cases involving government medical liens.[12]

But there is far more than anecdotal evidence to demonstrate that a rule granting priority to Medicaid reimbursement out of tort settlements does not effectively advance the government's goal of minimizing Medicaid outlays. One need only look to

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[11] Even in situations in which an attorneys' contingency fee may be calculated on the total recovery, an attorney may be reluctant to take on a plaintiff's claim because of the potentially awkward situation that might result. If the case results in a substantial recovery, most of which will go to the state Medicaid agency, the attorney could find him or herself faced with a client whose recovery is far smaller than the contingency fee. Although such a result may not be unethical, given the attorney's effective representation of both the injured plaintiff and the state agency, it would make many plaintiffs' attorneys uncomfortable. Rather than undertake a lengthy disclosure to a potential client about the potential complexities of this situation, many attorneys may simply opt to decline representation.

[12] All of these letters are on file with counsel and can be provided to the Court upon request.

the figures in the briefs of the *amici* supporting petitioner. In 2004, the Medicaid program expended a total of approximately $309 billion on medical care for indigent persons. *See* National Association of State Budget Officers ["NASBO"], *2003 State Expenditure Report*, at 47, *available at* http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf; *see also* Kaiser Commission on Medicaid and the Uninsured, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*, at 7, *available at* http://www.kff.org/medicaid/7190.cfm ("For FY 2004, total Medicaid expenditures will exceed $300 billion"). The Secretary of Health and Human Services estimates that "approximately 17% of all Medicaid beneficiaries have some form of third-party coverage for their medical expenses," Brief of the United States at 11, n.5, which would amount to around $52.5 billion. Yet, according to the brief of the United States, in 2004 Medicaid recovered only $1.6 billion nationwide in third party liability payments. Brief of the United States at 1. This amounts to far less than one percent of Medicaid's total outlays for indigent medical care, and barely three percent of the sum the government estimates is subject to third-party liability reimbursement.[13]

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[13] The data in the *amicus* brief submitted on behalf of 29 states and the District of Columbia leads to a similar—but even more stark—conclusion. The appendix to that brief provides information on the amount of third-party liability payments recovered by 26 states in the most recent year for which data is available. Brief of the State of Washington, *et al.* as *amici curiae*, at 1a-3a (some figures are estimates). The 26 states reported annual recoveries totaling about $142 million. By comparison, these same 26 states had total estimated Medicaid

By contrast, it is reasonable to assume that, if tort victims were given an appropriate incentive to seek recovery of the cost of their medical treatment along with compensation for their other injuries, Medicaid's third-party liability recoveries would grow significantly. In any number of other areas of law the government provides such incentives and empowers plaintiffs as private attorneys general to seek redress for wrongs committed against the public.[14] Thus, there is every reason to believe that a

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expenditures in FY 2004 exceeding *$125 billion*. NASBO, *2003 State Expenditure Report*, *supra*, Table 28, p.49. Thus, these states recouped barely one-tenth of one percent of their Medicaid expenditures through third-party liability reimbursement, significantly less than one percent of the amount the Secretary of HHS believes is potentially subject to recoupment. This data confirms that a rule requiring full reimbursement to the state agency prior to any recovery by the tort victim leads to recovery of only a tiny fraction of Medicaid expenditures.

[14] *See, e.g. Rotella v. Wood*, 528 U.S. 549, 557 (2000) ("[t]he object of civil RICO is thus not merely to compensate victims but to turn them into prosecutors, 'private attorneys general,' dedicated to eliminating racketeering activity.") (footnote omitted); *see also Alyeska Pipeline Service Co. v. Wilderness Society*, 421 U.S. 240, 262-64 (1975)(environmental law); *Agency Holding Corp. v. Malley-Duff & Associates, Inc.*, 483 U.S. 143, 151 (1987)(antitrust); *Newman v. Piggie Park Enterprises, Inc.*, 390 U.S. 400, 402 (1968) (per curiam)(civil rights); *Texas State Teachers Ass'n v. Garland Independent School Dist.*, 489 U.S. 782, 793 (1989)(First Amendment rights of public employees); *United States ex rel. Marcus v. Hess*, 317 U.S. 537, 546 (1943)(qui tam); *Scripps-Howard Radio v. Federal Communications Comm.*, 316 U.S. 4, 14 (1943)(communications law).

rule similar to that adopted by the Eighth Circuit, by increasing the possibility that injured plaintiffs would receive some compensation for their injuries, would increase Medicaid reimbursements and further the statutory purpose of reducing Medicaid costs.

IV. A Rule of Equitable Apportionment of Settlement Proceeds Would Conform to the Language of the Medicaid Act, Promote Judicial Economy, And Increase Medicaid's Third Party Liability Reimbursements.

Amicus urges this Court to construe the Medicaid Act in a manner similar to the construction adopted by the court below, and to provide guidance to state and federal courts on the proper application of the law to personal injury settlements. Specifically, *amicus* proposes that any settlement of a tort claim involving a Medicaid lien be equitably apportioned between various claimants and among various items of claimed damages.[15] In most cases, each claimant would be entitled to a share of the settlement equal to its share of the total damages reasonably claimed in the case. Such a statutory construction would fully conform to the statutory language of the Medicaid Act, promote the efficient resolution of judicial disputes, likely increase state Medicaid agency's third-party liability

[15] Although not directly at issue in the present case, state Medicaid agencies and other governmental health care providers often seek priority for reimbursement of medical expenses over the claims of claimants other than the injured plaintiff, such as family members who may be entitled to compensation for, e.g., loss of consortium.

reimbursements, and be equitable to all claimants, including the state and federal governments.

Where the parties cannot agree on an equitable division of the settlement proceeds, the trial court should convene a hearing to undertake such a division. All claimants—including those, like the state Medicaid agency, that have acquired their rights by assignment or subrogation—would receive notice of the hearing and an opportunity to be heard on the value of various items of damage in the case and a fair distribution of the funds.[16]

Such a post-settlement allocation hearing would not be unusual. As the Brief for the United States acknowledges, courts may "conduct post-settlement hearings to allocate settlements between taxable and non-taxable income categories." Brief for the United States at 17, n.7 (citing cases). Similarly, a number of states already have well-developed procedures in place for allocating the proceeds from a tort settlement. In Minnesota,[17] for

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[16] The trial court would not be bound by any agreement reached by some but not all parties to allocate settlement funds to particular categories of damages. This should eliminate any concern that the injured plaintiff might seek to "manipulat[e]" a tort award "to prevent the public from being reimbursed." *In re California Dep't of Health Servs.*, Dec. No. 1504 (HHS Jan. 5, 1995), Pet. App. 68, 81.

[17] Prior to the ruling below, Minnesota was the one state in which the state Medicaid agency's right to reimbursement for Medicaid payments was limited to that portion of any personal injury settlement designated for payment of past medical expenses, pursuant to a ruling of the Minnesota Supreme Court. *Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002), *cert.*

example, trial courts can convene a so-called "*Henning* hearing" to allocate settlement proceeds between categories of damages recoverable by a subrogated insurer and non-recoverable damages. *See Henning v. Wineman*, 306 N.W.2d 550 (Minn. 1981). To the same end, the Wisconsin Supreme Court has upheld a trial court's use of a "*Rimes* hearing," a post-settlement "mini-trial" to allocate proceeds. *See Rimes v. State Farm Mutual Automobile Ins. Co.*, 316 N.W.2d 348 (Wisc. 1982).[18]

In the experience of these states, once such a hearing procedure is developed, it is rarely used. Once all of the interested claimants understand the rules that govern the division of settlement proceeds, it is usually possible for them to agree to an allocation without the need for the time and expense of an allocation hearing. *See* Sharon L. Van Dyck & Wilbur W. Fluegel, *Determining "Full Recovery" Under the Minnesota Anti-Subrogation Statute*, Minn. Trial Lawyer Mag. 18 (Winter 1999).

Amicus recognizes, of course, that it would be inappropriate—and beyond the scope of this case—for this Court to establish specific procedures for state court judicial proceedings to allocate settlement proceeds; that is properly a matter for resolution by state courts and legislatures. Nevertheless, we outline these procedures here for two purposes: first, to reassure the Court that there are workable

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denied sub nom., Minnesota v. Martin, 539 U.S. 957 (2003).

[18] Such a settlement allocation hearing can also be utilized to determine the proper apportionment of litigation costs and attorneys' fees, where necessary.

procedures for resolving issues of equitable apportionment that need not burden trial courts with onerous satellite litigation proceedings; second, and perhaps more important, to encourage this Court to articulate standards for equitable allocation of settlement proceeds in cases involving Medicaid in order to guide the orderly development of such procedures in state courts.

A rule of equitable allocation would be entirely consistent with the Medicaid Act. The Medicaid recipient would assign to the state agency his or her "right to payment for medical care from any third party," 42 U.S.C. § 1396k(a)(1)(A), and the state agency would have "acquired the rights of [the Medicaid recipient] to payment by any other party for such health care items or services." 42 U.S.C. § 1396a(a)(25)(h). The equitable allocation hearing would ensure that the state agency received any and all settlement proceeds attributable to "such health care items or services." At the same time, by allowing the plaintiff to retain proceeds attributable to other items of damages, such a procedure would not run afoul of the Act's anti-lien provision. 42 U.S.C. § 1396p(a)(1).[19]

A rule of equitable allocation would also promote the efficient resolution of judicial disputes. A plaintiff would not be deterred from accepting a reasonable settlement offer from defendant(s) out of

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[19] Such a result would be fair and equitable to both parties. It would give priority neither to the claims of the injured plaintiff, as under the made whole doctrine, *see* fn.5, *supra*, nor to the reimbursement claims of the state Medicaid agency, as under the rule proposed by petitioner.

fear that the settlement proceeds would be swallowed up by the state Medicaid agency's claim for reimbursement. Instead, plaintiffs would be in a position to make a rational economic judgment, based on all of the facts and circumstances, about the reasonableness of the offer in light of the value of the claim, the litigation risk, and the resources of the defendant(s). It would likely become standard practice for plaintiff's counsel to consult with the state agency regarding the settlement offer and obtain its agreement to the acceptance and allocation of the offer.

Finally, a rule of equitable allocation would likely increase the recovery of Medicaid funds through third-party liability payments. By ensuring that injured plaintiffs will receive a fair share of any personal injury judgment or settlement, the rule will properly encourage the victims of tortious conduct to seek to recover for their injuries. And it will make it easier for them to retain counsel on a contingency fee basis. More claims will be vigorously pursued, with the result being a likely increase in the total amount recovered, by both tort victims and state Medicaid agencies.

The rule proposed by DHHS would create an inherent conflict between two entities whose interests should be aligned, the injured plaintiff and the state agency that paid for his or her medical care. By contrast, a rule requiring the equitable allocation of settlement proceeds properly affirms the commonality of interest between these parties, and thereby ensures that they can and will work together for the benefit of both.

CONCLUSION

For the foregoing reasons, *amicus curiae* the Association of Trial Lawyers of America urges this Court to affirm the ruling of the Eighth Circuit in this case.

Respectfully submitted,

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